MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Dorcest MARYI AND b. CITY OR TOWN (If outside corporate limits. c. LENGTH CF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled IS RESIDENCE d. STREET ADDRESS ON A FARM? NO YES With 3. NAME OF DECEASED First Middle DATE Last Month Day executed with event, (Type or print) DEATH 19 SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IF UNDER 24 HRS | Iast birthday) | Months | Days | Hours | Min. 7. MARRIED 8. remove. NEVER MARRIED Days any and WIDOWED X DIVORCED [ 6 YES. = 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work done I 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) þe during most of working life, even if retired) INDUSTRY death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova MIE 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | (If yes pive war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMAN Address BOX167A 10 ed by the atte transit permit cremation, or in Ma been signed by the burial-transit pion to burial, cremati CAUSE OF DEATH [Enter only one cause per line for (a). INTERVAL BETWEEN law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a) DUF TO Conditions. If any, which (b) gave rise to immediate DHF TO cause (a), stating the prior t underlying cause last. (c) 38 CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO SEATH BUT NOT 19. WAS AUTOPSY THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health The PERFORMED? certificate the hospital or NO Z YES [ **PHYSICIAN:** 20a, ACCIDENT WAS UNDERLYING IT DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part | or Part | of item 18.) t. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detache e Dept. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While After retained by at work at work p.m. o 21. I certify that (1) (this hospital) attended the deceased from # that (I) (we) last DIRECTOR: age 3 should led with the and that death occurred attack M. from the causes and on the date stated above. saw the deceased alive on 22a. SHBNATURI 22b. DATE SIGNED **98** page ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. Page 4 may PHYSICIAN'S 22c. ADDRESS director, p 1FFD 23a. BURIAL, CREMATION, 23b. DATE THEREOF OF CEMETERY OR CREMATURY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 2 BUY A PE FUNERAL DIRECTOR ADDRESS. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20M 1/65

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e. IS RESIDENCE ON A FARM?

Ooy

Doys

12. CITIZEN OF WHAT

TISA

COUNTRY?

YES NO TO

Year

1967

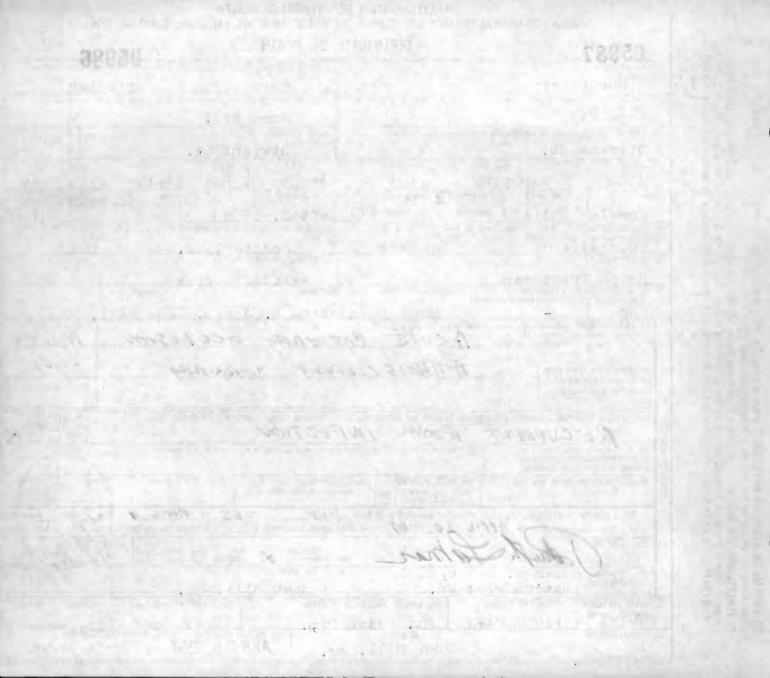
IF UNDER 24 HRS.

Hours

WAS AUTOPSY PERFORMED?

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

NO PO the hospitol or (County) (Stote) O FUNERAL DIRECTOR: After be retoined by . 1963 to APRIL 2 , 1967, that (1) (we) last saw the deceased affive on APRIL 20 1967, and that death accurred at \_\_\_\_\_\_M, fram causes and an the date stated above. 22b. DAJE SIGNED, MED. M.D. director, page 3 should be filed v PHYS. DIRECTOR PHYS. 22d. ADDRESS La Mar. 22c. PHYSICIAN'S Robert NAME (Type) Namick Ranfort x Mck Snow Hill 23o. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Mt. Olive Cem. Near Snow Hill 24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR 25b. REGISTRAR'S VR A15 (4) 20 M 1/66 Hill, Md.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 05988 HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY orcester any delay is 1, 2, and 3 ta m PM3. Page a. COUNTY a. STATE Worcester MARYLAND Maryland b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 15 regular Nite c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) acz with the State Departme WHALEYVILLE Rural shift employee Showell . d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Officerationg with farm R # 1 Box 177-C B & S Hatchery in Item 18. Give Pages YES NO X 24 haurs after death. 3. NAME OF Middle Last 4 DATE Month Day Year DECEASED April 22 1967 William Mac Fee Long DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIEDXIX NEVER MARRIED B. DATE OF BIRTH last birthday) Days Hours White Male. WIDOWED DIVORCED July 12, 1912 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRYS Worcester County pages I in any ward "pending" in pencil in the Chief Medical Examiner's Hatchery employee Chick Hateherv pencil 14 MOTHER'S MAIDEN NAME This certificate should be executed within Vernon M. Long Margaret Baker pup 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar unknown) (If yes give war or dates of service) removal. 213-18-5196 Whaleyville, Maryland Mrs. Rada Long. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) e used as a burial-transit o burial, crematian, ar re PART I. DEATH WAS CAUSED BY: ONSEL AND DEATH ACUTE CORONARY OCCLUSION IMMEDIATE CAUSE (a) icate, writing the ward be farwarded to the Ch DUE TO Coronary atheroscloebsis unknown Conditions, if ony, which gave rise ta immediate cause (a), DUE TO stating the underlying cause 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(9) PERFORMED? please execute the certificate, NO designated agent, priar to 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3 should PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour a.m factory, street, office bldg., etc.) Not While FUNERAL DIRECTOR: Page at work at wark 21. I certify that I taok charge of the remains described above, held an Autapsy Inspection \*x Inquiry & and in my apinian Matural causes XX death resulted fram: Accident Suicide [ Hamicide Undetermined manner CHIEF MEDICAL EXAMINER 5 may be reta TO FUNERAL DI Health or its of ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER XX EXAMINER'S. NAME (Type) ROBERT C. LA MAR, M.D. 104 Bay St Saldres (17401 dry, 1947), or county) 4-24-67 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Tawn) 23a BURIAL, CREMATION, Buffle (pecify) Lewis Cemeterv Whaleysville. Worces. Md. 25b. REGISTRAR'S SIGNATUR 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Jatan Selbyville, Dela. DATEAPR 27 1967 VR A15ME (5) 6M 1/66

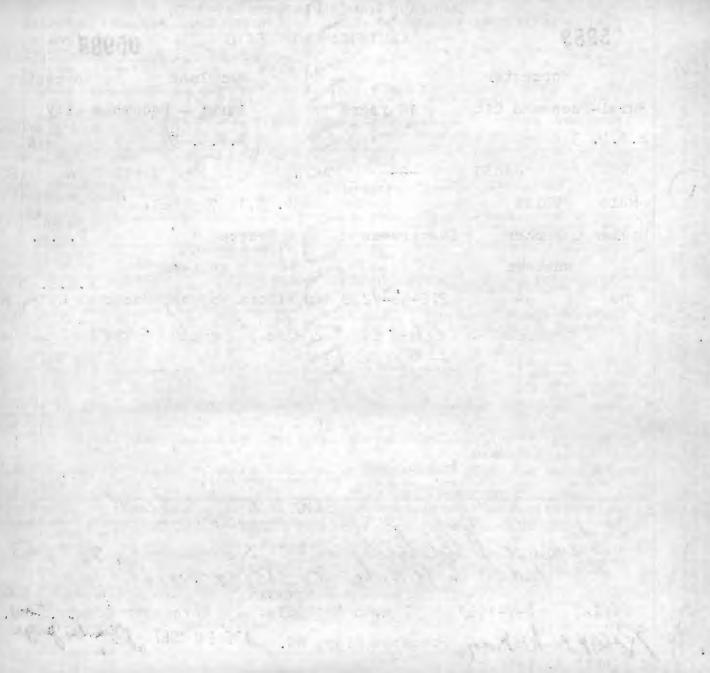
MARYLAND STATE DEPARTMENT OF HEALTH

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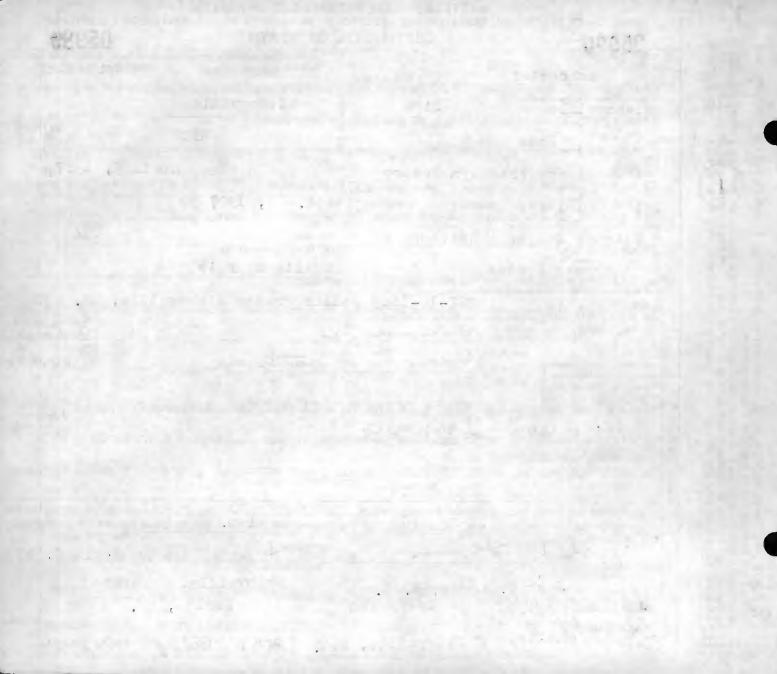
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05989 CERTIFICATE OF DEATH death. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) b. COUNTY after Worcester Maryland MARYEAND Worcester CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Page hours Rural-Pocomoke City 10 years Rural - Pocomoke City d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? R.F.D. R.F.D. YES X NO within ely nog NAME DF First Middle Lest DATE Month Day Year DECEASED JAMES PAPPAS (Type or print) April 19 67 DEATH executed 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED X NEVER MARRIED 9. last birthday) | Months | Davs Hours Male White Sept. WIDOWED [ DIVORCED . 1897 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR physician in please r 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? Dealer & Broker Evergreens U.S.A. Greece 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova unknown unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. 0 death (Yes, no, or unkown) (If yes give war or dates of service) 216-48-723 No Mrs Elnora Pappas cremation, Pocomoke the been signed by the the burial-transit of to burial, cremati 18. CAUSE DF DEATH [ Enter only one cause per line for (a), (b), end (c). INTERVAL BETWEEN that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if eny, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. 83 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY use for use Health certificate PERFORMED? NO F YES the hospital PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING I DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) ofo OR CONTRIBUTING T CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) le l 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While p.m. at work at work 70 21. I certify that (I) (this hospital) attended the deceased from 2001 DIRECTOR: age 3 should lied with the . that (I) (we) last PM, from the causes and on the date stated above. saw the deceased alive on. and that death occurred at// 22a. SIGNATURE 22b. DATE SIGNED 6 8 page DIRECTOR TO HOSPITAL (Page 4 may M.D. PHYSICIAN'S FUNERAL 22d. ADDRESS director, p NAME (Type) NAME OF CEMETERY OR KENENCATORYX BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, town or county) (State) 2 REMOVAL (Specify) 4-7-1967 Remson Methodist Burial Worcester County Md REC'D BY REGISTRAR | 25b. REGISTRAR'S SI FUNERAL DIRECTOR 25a. Pocomoke City. Md. VR A15 (4) 20M 1/65 Robert Watson H

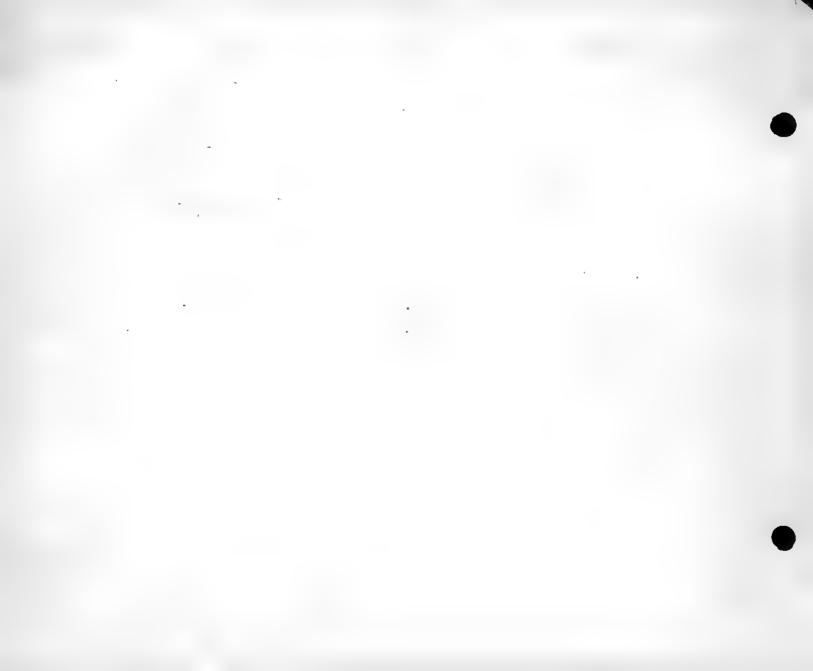


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 05996 PLACE DE DEATH USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY Maryland b. COUNTY Wordester after Worcester MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b 3 hours Bishopville Life Bishopville E on papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE filled d. STREET ADDRESS ON A FARM? RFD Home YES PET NO tely thon p within NAME OF Middle DATE Month Day Year 3. First Last 4. DECEASED April and comple remove part Rov Franklyn (Type or print) executed AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE DATE OF BIRTH 9. last birthday) Months I 7. MARRIED NEVER MARRIEDAX Davs and 18, Sept. WIDOWED DIVORCED Colored Male 10a, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT .5 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) physician lease and ir be INDUSTRY Maryland Kitchen Helper Restaurant death certificate 0 removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending I Dollie Sturgis Predow Cyrues 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address ed by the attenctransit permit. (Yes, no, or unkown) ! (If yes nive war or dates of service) Dollie Predow Bishopville, Md. RFD 222-10-6663 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), signed by th PHYSICIAN: The law requires that the the hospital or attending physician. ONSETNAND DEATH PART I, DEATH WAS CAUSED BY: days IMMEDIATE CAUSE (a) has been signed as the burial-tr-prior to burial, c DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO (a), stating the underlying cause last, has 19. WAS AUTOPSY CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health p this certificate h detached for use e Dept. of Health I PERFORMED? NO X YES 208. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part | or Part || of Item 18.) WEDICAL (State) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) After the de de de State f Hour a.m. While Not While be retained by at work at work p.m. 1965 19 67 that (I) (we) last April DIRECTOR: A age 3 should led with the uctober 21. I certify that (I) (this hospital) attended the deceased from D.M. from the causes and on the date stated above. saw the deceased alive on Apr 6 and that death occurred at -22b. DATE SIGNED 228. SIGNATURE page ATTENDING. PHYS. STAFF PHYS. April DIRECTOR TO HOSPITAL UP Page 4 may 1 TO FUNERAL D M.D. 22CE\_PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) Selbyville, Delaware Jack 236 NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, rin, Ma. (State) 23a. 25b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR FUNCEAL DIRECT ADDRESS Selbyville, Del. VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) PLACE OF DEATH o (O.JNTY 3 to Page b COUNTY ORCESTE MARYLAND C LENGTH OF STAY IN 15 c CITY (GWN (If outside corparate i mits\_write RURAL and give nearest town) ouo P.M3 after hours YES Give Pages M ddle 3 NAME OF DATE DECEASED OF EMAN (Type or print) DEATH IF UNDER 24 HRS S SEX AGE (In IF UNDER I YEAR 6 COLOR OR RACE Months Hours in item 18. WIDOWED hours Office BIRTHPLACE (State or foreign country) 106 KIND OF BUSINESS OR 100 JSUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT Q) during most of working life, even if retired) INDUSTRY WINASOK, VIRGINIZ HOUSE WI dny poges in any pencil ond INFORMANT ARMED FORCES? remayal (Yes no, or priknown) (If yes give war or dates of service 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) pnd (c).) buriol-transit PART I DEATH WAS CAUSED BY CCIUSION 5 IMMEDIATE CAUSE (0) should the word cremation, DHE TO ASCUD Conditions, if any, which gave rise to immediate couse (o). DUE TO certificate stoting the underlying couse 0 ost. used as burial, a PART II OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ILO WAS AUTOPS PERFORMED? 0 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 3 should ogent, prior PRIMARY ☐ or CONTRIBUTING ☐ AL EXAMINER: CAUSE OF DEATH 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm 20f ((ity or town) (County) (Stote) While factory, street, office bldg., etc.) FUNERAL DIRECTOR: Poge ot work pleose execute or its designated 21 I certify that I took charge of the remains described above, held on Autopsy ond in my opinion death resulted from Natural causes Suicide [ Undetermined manner Homicide be retained CHIFF MEDICAL EXAMINER **ACTUAL** SIGNATURE O DEPUTY **EXAMINER'S** Health NAME (Type) 230 BURIAL, CREMATION, (County) 0 2So REC'D BY REG STRAR 24 FUNFRAL DIRECTOR VR A15ME (5)



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35992 CERTIFICATE OF DEATH 05991 requires that the death certificate be executed Within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1. PLACE OF DEATH a. COUNTY 5. COUNTY prystrain. signed by the attending physician and campletely filled in by the functional burial-transit permit. Then please remave tarban papers. Pages 14 burial transition or removal, and in any event, within 72 hours after Worcester MARYLAND Maryland Worcester b. CITY OR TDWN (f autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (14 autside carparate limits, write RURAL and give nearest tawn) Snow Hill Snow Hill d. NAME OF HOSPITAL DR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENC DN A FARM? 11 111 W. Federal YES ND W 3. NAME OF 4. DATE Middle Month Year OF DEATH DECEASED 19 67 Benjamin April (Type at print) Truitt IF UNDER 24 HRS. AGE (In years IF UNDER LYEAR 6. COLDR DR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday last Manths Days Hours WIDDWED DIVORCED Mala 9. 1898 69 YES White 12. CITIZEN OF WHAT 10o USUA, DCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) CDUNTRY? Fertilizer Snow Hill. Maryland General Manager TISA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Sally Mary Fooks Benjamin T 16. SOCIAL SECURITY NO 17 INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes a ve wor or dates of service Snow Hill. Yes B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) ONSET AND DEATH PART I DEATH WAS CAUSED BY HCHEKIA INANITION IMMEDIATE CAUSE (a) DUE TO ADENO CARGNOMB OF PROSTATE Conditions, if only, which gove rise to immediate cause (o), WITH METASTISES DUE TO stating the underlying cause the has been last. WAS AUTOPS' PERFORMED? PART II DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) O FUNERAL DIRECTOR: After this certificate 200 ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY DCCURRED (Enter nature of injury in Part I or Part II of item 18) DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME DF INJURY Month, Day, Year 20d INJURY OCCURRED 20a. PLACE OF INJURY (Home, form. (City or town) (County) (Store) Hour a.m. Nat While factory, street, office bldg., etc.) at work ot work 1963, to BPRIL 27, 1967, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from JUNE be retained shauld APRIL 27 1967, and that death accurred at 7:150M, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE 226. DATE SIGNED ATTENDING STAFF PHYS. DIRECTOR PHYSICIAN S NAME (Type) 22d. ADDRESS C. LaMar, M. D. 104 Bay Street, Snow Hill, Maryland Robert directar, shauld b 23c. NAME OF CEMETERY DR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF (County) (Stote) 230 BURIAL CREMATION Burial (Specify) 11/30/67 Maryland Episcopal Snow H111 2So., REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 19 20 M 1/66 1967 Charles Snow Hill Maryland

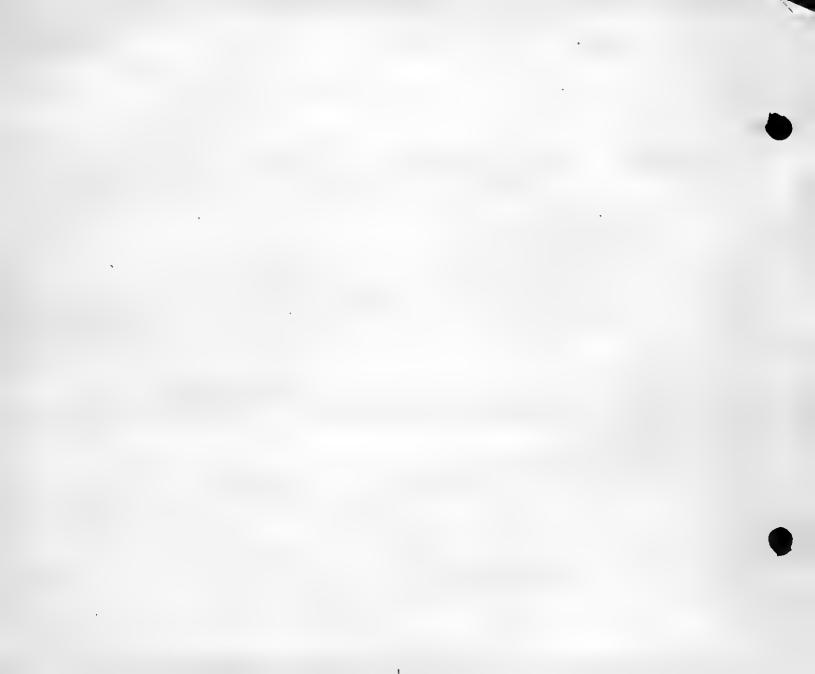
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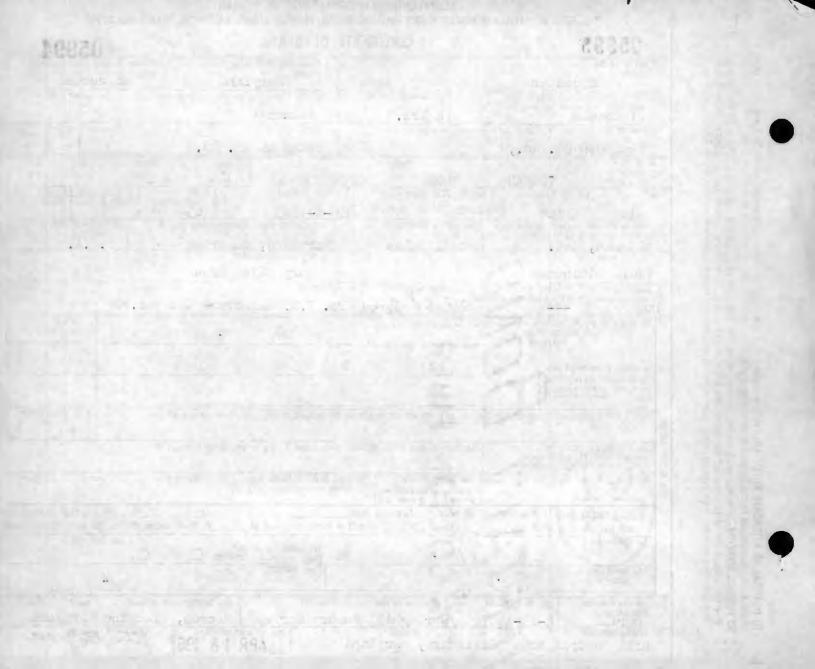
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY b. COUNTY o STATE Page P MARYLAND b CITY OR TOWN (if autside corporate limits CLENGTH OF STAY IN 16 ( floutside corporate lights write RURAL and give nearest town) C CITY OR TOWAL gud werte RURAL land give marest town) d STREET ADDRESS e IS RES.DENCE d NAME OF HOSPITAL OR INSTITUTION (II not in hospital, give street oddress) ON A FARM NO N in Item 18. Give Pages NAME OF Middle Year First OF DEATH DECEASED Type or print) Office alayg IF UNDER 24 HRS 7 MARRIED X 6 COLOR OR RACE NEVER MARRIED thdoy Months Hours WIDOWED DIVORCED any event with n 72 haurs after death 12 CITIZEN OF WHAT 10b KIND OF BUS NESS OR COUNTRY ? INDUSTRY pending" in pencil in ef Medical Examiner's 13 FATHER'S NAME 14. MOTHER S MAIDEN (Yes no for unknown) (If yes giverwar or do les of service 8. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) writing the ward DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stoling the underlying couse lost. nsed WAS ALTOPS: PERFORMED? remayal, PART II OTHER S GNIFICANT COND TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO 20o. EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 11 of item 18.) 3 should PRIMARY Dor CONTRIBUTING D crematian, ar CAUSE OF DEATH MEDICAL 20e PLACE OF INJURY (Home form 20t (City or town) 20c T ME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (ounty) (Stote) Hour o.m. While foctory, street, office bldg., etc.) Not While FUNERAL DIRECTOR: Page please execute at work of work 21. I certify that I taok charge of the remains described above held on Autopsy [7]. Inspect an D and in my apinian death resulted from Natural causes Hamicide Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Health priar **EXAMINER'S** Address (Street city, town or county) NAME (Type) BURIAL, CREMATION. 0 REMOVAW(Specify) 250 REC D BY REG STRAR 24 FUNERAL DIRECTOR VR A 15ME (5)



and state department of Health Division of STATISTICAL REST RCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE 1. PLATOE OF LEATH peredivil arishor Reser USUAL RESIDENCE Whater Worcester MARYLAND b. CIY OR TOWN (if outs do corporate limits, c. LENGTH OF STAY IN 15 c. C.TY OR TOWN (If outside corporate imits, with RURAL and give in least town Ocean City Ocean City d NAME OF HOSPITAL OR NSTITUTION if not in hospitel ig we stiest laddress d STREET ADDRESS RESIDENCE ON A FARM? 1504 Shad Road 1504 Shad Road YES NO T 3. NAME OF DATE Yeer DECEASED OF (Type or print) Robert Wilson White DEATH 1967 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED THE DAYS OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthdey) Months Male WIDOWED DIVORCED [ 10a. USUAL OCCUPATION (Give kind of work 105. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Salesman Sold cutlery Snow Hill, Md. U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Edward White Mary Wilson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyesgive werordetesofservice) Mrs. Robert White (wife) Ocean City 18. CAUSE OF DEATH (Enter only one couse per line for (e). (b), end (c) ) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Bullet wound in head (Self-inflicted) MMEDIATE CAUSE (a) Instant DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying PART I . OTHER SIGNIF CANT COND TIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1101 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of Item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY [] or CONTRIBUTING [] CAUSE OF DEATH. 20c. TIME OF INJURY 20d. INJURY OCCURRED 20s. PLACE OF INJURY (Home, ferm. ; 20f. (City or town) (County) fectory, street, office bldg., etc.) While Hour e.m. Not While et work et work Inspect on 21. I certify that I took charge of the remains described above, held an Autopsy Inquiry V and in my opinion death resulted from: Natural causes Accident Suicide | Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER should | EXAMINER'S ò NAME (Type) Address (Street, city, town, or county) please 4 shour 70 FUN Health Schatte TEMPTER OR CREMATORY 228 BURIAL, CREMATION 725 22d. LOCATION (City, town, or country) Burial Presbyterean Cemetery Snow Hill ADDRESS 23. FUNERAL DIRECTOR 24a. REC'D BY REGISTRAR | 24b. REG STRAR'S SIGNATURE VR ATSME Mrs. Anna A. Burbage Berlin, 5M 1/62



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05995 requires that the death certificate be executed within 24 haurs after death the tuneral 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH b. COUNTY Worcester o. COUNTY Maryland Worcester MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 4 Yrs. Pocomoke Pocomoke I completely filled in b nove carbon papers. ny event, within 72 ho e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS BethEden Ch. Rd. YES IN NO BethEden Ch. Rd., 4. DATE Month 3. NAME OF Middle Lost Doy Year remove carbon DECEASED 1967 ROWE WIDDOWSON 10 THOMAS DEATH (Type or print) IF UNDER 1 YEAR | IF UNDER 24 HRS. 9. AGE (In years B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours DIVORCED WIDOWED 10-6-1903 White Male 10o, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT INDUSTRY
Retail Sales **COUNTRY?** U.S.A Salesman, Ret. Maryland. Somerset 14. MOTHER'S MAIDEN NAME or remove Mary Ellen Rowe Frank Widdowson n signed by the attending p burial-transit permit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMANT 16. SOCIAL SECURITY NO. Mrs. T.R. Widdowson See Sec.#2 INTERVAL BETWEEN ONSET AND DEATH 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gove rise to immediate couse (o), Disease **DUE TO** stoting the underlying couse Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been the rto lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? CERTIFICATION for use Health NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Hour o.m. Not While of work at work 19 ( /that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. Ch. 10 1967, and that death accurred at M, fram causes and an the date stated abave. saw the deceased alive an\_ 22b. DATE SIGNED 22n. SIGNATURE 10-12-6 DIRECTOR M.D. PHYS. 22d, ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (County) 230. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)
Burial Hebron, Wicomico Maryland Springhill Memory Garden 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 1961 Salisbury, Maryland 18 VR A15 (4) 20 M 1/66 Hill Funeral Home



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if Institution: a. COUNTY b. COUNTY: DREE hours after by the RCUST MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TZ hours write RURAD and give nearest town = filled d, NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS DN A FARM? NO YES pletely NAME OF DECEASED First Middle Last 4. DATE Month Oav (Type or print) AMS DEATH 19 lease remove ca executed COUNT 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS | last birthday) | Months | Days | Hours | Min. 7. MARRIED 8. NEVER MARRIED WIDDWED DIVORCED physician and please re 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS DR 12. CITIZEN OF WHAT (County & State, or foreign country) certificate be during most of working life, even if retired) COUNTRY? Ta RED removal, 13. FATHER'S NAME MDTHER'S MAIDEN NAME n signed by the attend burial-transit permit. burial, cremation, or re 16, SOCIAL SECURITY NO. Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT death (Yes, no, or unkown) (If yeagive war or dates of service) 0 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN OR ATTENDING PHYSICIAN: The law requires that the be retained by the hospital or attending physician. ONSET AND CEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a DUE TO Conditions, If any, which FUNERAL DIRECTOR: After this certificate has been lirector, page 3 should be detached for use as the bhould be flied with the State Dept. of Health prior to b gave rise to immediate **DUE TO** cause (a), stating underlying cause last CERTIFICATION WAS AUTDPSY PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO X YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) CAL (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. MEDI While Not While ALTENDING at work at work 21. I certify that (1) (this hospital) attended the deceased from PAPRIL AM, from the causes and on the date stated above. saw the deceased alive and that death occurred at 22b. DATE SIGNED 226. SIGNATURE ATTENDING MED. DIRECTOR D Page 4 may PHYS. M.D. PHYSICIAN'S NAME (Type) ADDRESS 22c. director, p should be 1 ROBERT (State) BURIAL, CREMATION. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. 23b. DATE THEREOF REMOYAL (Specify) 2 0 RIAL FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADORESS VR A15 (4) 15M 4-64

ALVIE PULMONARY EDEMA 2 20195 TOPE E FREDING INSUPFICIENCY ADVANCED BY CONSHIET TOSIS + MILD EMPHEREMA